Employer-sponsored health insurance migration to public health insurance exchanges: Potential effect on exchange premiums

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The employer-sponsored healthcare insurance market represents the largest single health insurance segment in the United States. With 156 million individuals currently receiving healthcare coverage through employer-sponsored insurance, employer decisions may impact public health insurance exchange premiums.

There are 6.7 million individuals who purchased health insurance on public exchanges[1] and 156 million individuals who receive coverage through employer-sponsored health insurance in 2014.[2] Given the relative sizes of these markets, even modest migration from employer-sponsored plans to the individual market may have a significant effect on public health exchange premiums. There are many potential factors, including guaranteed issue requirements and the availability of subsidies to low- and moderate-income individuals, that may contribute to a shift from employer-sponsored plans to the individual health insurance market in the coming years.

Public exchanges, which are online marketplaces where individuals can purchase health insurance, are an alternative to employer-sponsored health insurance programs. If employers decide to transition from current defined benefit healthcare programs to either a defined contribution program or no health insurance program, employees and covered dependents may migrate to public exchanges to purchase health insurance. Migration of individuals from the employer-sponsored insurance market to public exchanges may decrease public exchange premiums to the extent that the average employer-sponsored insurance claims are less than current public exchange claims. Conversely, public exchange premiums would increase if the health status of the new entrants from employer-sponsored coverage is worse than that of the current public exchange membership.

If smaller employers that have several employees with chronic health conditions drop their coverage and steer their sicker employees to the public exchange, the average morbidity of the public exchange membership would increase. However, if larger employers whose employees and their dependents exhibit a cross-section of healthy and less than healthy lives, the morbidity level of the public exchange would likely decrease, resulting in lower rates on the public exchanges.

We estimate that public exchange premium rates could decrease by 4.9% to 9.0%, assuming that a 5% cross-section of the current employer-sponsored insurance membership migrates to the public exchange and that the claims from a typical member in the public exchange are 10% to 20% higher than the claims of a typical member in employer-sponsored insurance.

In this example, the migration of a 5% cross-section of the employer-sponsored insurance membership to the public exchange represents roughly 7.8 million individuals (or approximately 3.6 million employees)

[1]U.S Department of Health & Human Services (October 17, 2014). Medicaid and CHIP Enrollment Grows by 8.7 Million Additional Americans. Retrieved December 8, 2014, from http://www.hhs.gov/healthcare/facts/blog/2014/10/medicaid-chip-enrollment-august.html.

[2]Congressional Budget Office (April 2014). Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014. Retrieved December 2, 2014, from http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231=-ACA_Estimates.pdf.

moving to the public exchange. This would more than double the current 6.7 million public exchange enrollment estimate.

The table in Figure 1 presents a range of estimated public exchange premium rate reductions based on three migration scenarios and three relative morbidity scenarios.

Figure 1: Estimated Public Exchange Premium Increase

Individual to Employer-Sponsored Claim Relativity	Percent of Employer-Sponsored Insurance Membership That Migrates to the Public Exchange		
	2.5%	**5%**	**10%**
90%	4.1%	6.0%	7.8%
100%	0.0%	0.0%	0.0%
110%	-3.3%	-4.9%	-6.4%
120%	-6.1%	-9.0%	-11.7%

A 110% individual to employer-sponsored insurance claim relativity means that individual average allowed claims are 10% higher than employer-sponsored insurance average allowed claims, reflecting differences such as demographic, geographic, morbidity, provider reimbursement rate, and benefit design differences.

It is difficult to anticipate the extent to which large employers will decide to transition to either a defined contribution program or no health insurance program and send employees to the public exchange. In addition, relative morbidity of the employer-sponsored insurance market to the public exchange market is difficult to estimate, which is due to the limited claim experience of the public exchange. Migration of larger employer groups to the public exchange is more likely to result in a decrease in the average morbidity level of the exchange than would the migration of several smaller employers.

METHODOLOGY

We assumed that exchange premium rates are developed using a target loss ratio approach, which means that a percent change in claim costs translates directly to a percent change in premium rates. To the extent that there are fixed expenses associated with the public exchange, the increase in membership on the exchange that is due to migration of employers will reduce premium rates because that expense would be spread over a larger membership base.

We performed a literature review of material published by Milliman, the Society of Actuaries, the American Academy of Actuaries, the Henry J. Kaiser Foundation, and others to research the relative claim costs of public exchange members compared to employer-sponsored insurance members. Sources currently available generally focus on morbidity differences between individual and group insurance products in the marketplace before the Patient Protection and Affordable Care Act (ACA). It is difficult to surmise relevant conclusions about the morbidity of public exchange members, which is due to varying allowable underwriting practices and regulatory restrictiveness at the state level before the ACA. As a result, morbidity difference assumptions are illustrative estimates based on the experience of the authors of this report.

Since public exchanges have been operational for less than one year, limited information has become available on which a sound actuarial analysis may be performed. Based on our analyses of this limited information, along with Milliman data on morbidity differences that are due to underwriting change and case size from our 2014 Health Cost Guidelines™ and experience of the consultants conducting this analysis, we believe the difference in morbidity levels may be between 10% and 20% higher in the individual public exchange compared to the large group employer-sponsored insurance market. This estimate is after the initial pent-up demand effect from previously uninsured members has diminished on the public exchange, along with the migration to the exchange by the transitionally insured population that has been allowed to retain its existing coverage.

The ACA introduced three important market reforms that increase the ease with which competitors can compare premium rates on the exchange: (1) standardization of benefit designs, (2) uniform rating rules, and (3) transparency requirements. We have information on market concentration in multiple states (as measured by market share and the Herfindahl-Hirschman Index), but are hesitant to attribute changes in 2015 premium rates to market competition, employer-sponsored insurance migration, or relative morbidity, which is due to the immature and unstable nature of the exchange markets.

IMPORTANT DISCLOSURES

This communication has been prepared for the specific purpose of estimating the effect of employer-sponsored insurance member migration on public exchange premium rates. This information may not be appropriate, and should not be used, for any other purpose.

In performing this analysis, we relied on information published by others. If this data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

This communication has been prepared solely for the internal business use of, and is only to be relied upon by, the management of the American Health Policy Institute. While Milliman has agreed that this report may be shared by the American Health Policy Institute, Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. This communication must be read in its entirety.

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Milliman does not provide legal advice, and recommends that American Health Policy Institute and others consult with its legal advisors regarding legal matters.

CONTACT

If you have any questions or comments on this document, please contact Bill Thompson or Dave Liner, who are actuaries with Milliman. Bill and Dave are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

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